

DALLAS COUNTY PUBLIC HEALTH

Health Navigation

Toolkit

2013

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Introduction

This toolkit was compiled to share a program, Health Navigation, developed by Dallas County Public Health (Iowa). Health Navigation is a community utility to coordinate existing services in the community and to support the patient centered medical home model. A community utility is a service that is provided to the community that everyone contributes to and everyone benefits from for something that cannot be accomplished efficiently alone, like the provision of electricity.

Locating and accessing needed services in the community can be difficult, confusing or even overwhelming. This can be true for community residents, community agencies and healthcare providers. Healthcare providers and community agencies can refer patients to Health Navigation services. And, residents looking for a medical home or additional assistance can contact Health Navigation directly for help in locating a medical home or to be connected to existing community services/programs.

Health Navigation was developed over a 5 year period in response to a need identified by Dallas County providers and residents. Funding to support Health Navigation efforts was received from Iowa Collaborative Safety Net Medical Home Grants, Mid Iowa Health Foundation, Community Transformation Grant/Iowa Department of Public Health and United Way of Central Iowa. Development of this toolkit was funded by Community Transformation Grant/Iowa Department of Public Health.

While information shared in this toolkit is specific to Dallas County, it is hoped that tools and lessons learned can assist other local public health departments and community coalitions. Health Navigation can be used to help support integrated care models and a redesigned care delivery system.

For more information on Dallas County Health Navigation, contact Shelley Horak
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Issue and Vision

Identify the Specific Gap/Issue

Health Navigation was developed as a response to an unmet community need. When identifying a specific gap or issue in the community, it is important to reach out and get input from a broad group of people. This includes:

- Current coalitions/partnership groups
- Community partners
- Residents
- Stakeholders/key informants
- Primary Care Providers
- Those not previously worked with but who may have an interest

Gather Information and Data

It is also important to gather information and data as evidence of the issue's existence and impact on the community. Sources of data and information available in the community might include:

- Community Health Needs Assessment
<http://www.idph.state.ia.us/chnahip/HealthImprovementPlans.aspx>
- Hospital Emergency Department Use
- Hospital Readmissions
- Number and/or percent of uninsured, Medicaid, chronic health issues, etc.
- Anecdotal stories

Clarify the Vision

Once the issue has been identified and information regarding the issue has been gathered, the community must come together to clarify a vision for addressing the issue. While agreement on all details of a solution is not necessary, a general consensus of vision is critical to the future success of the project. Following are some suggestions and considerations when clarifying the vision:

- Brainstorm with your coalition
- Consider using an outside facilitator
- Discuss and focus on key words and themes that emerge
- Think about scope and manageability
- Make sure there is agreement/buy-in from key partners
- Emphasize the vision belongs to the community, not one agency or faction
- Consider creating a graphic of your vision; this can make the vision easier to share with the broader community and potential funders

Dallas County's Issue & Vision

Dallas County's Partnership for Health utilized information from the Community Health Needs Assessment and interviews with key informants to identify the issue as "lack of access to care and confusion regarding community resources and programs including eligibility, benefits, and application processes". In an interview one of the key informants described the situation as, ". . . a patchwork of programs/resources with no central point of information or coordination".

Dallas County Partnership for Health determined the need for an online Resource Directory and a Health Navigator. The vision statement:

“Residents of Dallas County will have access to available resources in the county through one point of contact, with emphasis on timely referrals, fewer steps to receipt of care, efficiency, increased options and improved outcomes.”

Based on this vision, a graphic was developed ***Graphic of Dallas County’s Vision (Appendix A).***

How it Works

The Nuts and Bolts of the Program

When developing a program based on the vision, it's a good idea to start by asking questions. Here are a few to get started:

- Has anyone done this or something similar?
- Can we learn from their attempts and mistakes?
- Have we checked with IDPH, the Iowa Collaborative Safety Net Network or others who may be aware of similar projects?
- Have we done an internet search for related projects/ideas?
- Have we talked with or visited those identified to learn more?

There are many items to be considered when planning a new project/program. Considerations include:

- Mode/location of interactions (phone, face to face, office, home, clinic)
- Depth of involvement with the patient/client
- Staff functions and job descriptions
- Tools, forms, training required
- Interpretation and translation; if so, what languages are needed
- Policy and procedures; best practices
- Implementation timeframe
- Cost, both start-up and ongoing

Dallas County's Nuts and Bolts (aka How it Works)

A healthcare provider or community agency can refer an individual to Health Navigation; or, a resident can self refer. Referrals from healthcare providers are considered Tier 1 referrals and given priority. All other referrals are considered Tier 2 referrals.

If the referral is from a healthcare provider, a Clinic **Referral Tool (Appendix B)** is completed by the healthcare provider and faxed to Health Navigation. The Health Navigator contacts the client within 3 days and utilizes the **Screening Tool (Appendix C)** to gather additional information. Based on the information gathered, the Health Navigator assists the client in obtaining appropriate resources. This could include access to and payment for medical care including medications; mental health/substance abuse treatment; basic needs such as food or safe, affordable housing; parenting/childcare; or aging issues.

Information on client, source of referral, contacts and referrals provided is entered into the database in accordance with the **Health Navigation Database User Manual (Appendix D)**. The Health Navigator makes follow-up contact with the client in accordance with **Health Navigation Policy (Appendix E)**. If the original referral was Tier 1, from a healthcare provider, information is provided back to the healthcare provider regarding Health Navigator and client actions.

From the start, it was deemed important to the success of the program that Health Navigation be client-focused. Client-focused characteristics incorporated in Health Navigation include:

- Active engagement of the client
- Focus on client's current need
- Provide the client information and support to make decisions

- Respect client choice and empowerment
- Mode/location of the contact should be determined by client (phone or in-person; home, office, library, Burger King)
- Client guides the level of screening tool information collected
- Health Navigator will provide hands on assistance (applications, paperwork, interpretation) when necessary and with the client's request/permission
- Level of involvement, number of contacts and timeframe will be driven by the individual client and situation

The staff range of skills and knowledge needed for Health Navigation is broad and includes:

- Local, state, federal resources
- Children and families
- DHS, Medicaid
- Aging, Medicare
- How insurance works
- Health/Medical

Based on this range of knowledge and skills, the model developed in Dallas County decided to utilize a team approach including a nurse, social worker, and community health worker.

Outreach/Marketing

Getting the Message Out

Once the program is developed, it is important to get the word out. Explaining the program and how it works isn't always as easy as it seems. One message does not fit all audiences. Tailor the message to the audience. Continually "market" the program. If a healthcare provider has not utilized or referred to the program for a while, the provider may have forgotten how the program works. Keep the program in the forefront of the provider's vision, remind them frequently and make it easy for them to refer to the program. Here are some important aspects to getting the message out about the program:

- Name & branding
- Who is the target audience?
- Do some research on your target audience
- Highlight what the program can do for the target audience
- Letting the audience know what you can't do is as important as letting them know what you can do
- Try to show how the program/service fits into the big picture
- Find champions
- Recognize each clinic/healthcare provider setting is unique

Dallas County Messaging

A ***Health Navigation Outreach Card (Appendix F)*** was developed and distributed to healthcare providers, community agencies and libraries. The card outlines what Health Navigation can do to help:

- Screen for needs and refer/assist client in obtaining needed services and resources
- Help with access to; and, payment for medical care
- Help with access to medications
- Connect to non-medical community services such as housing, heat assistance, childcare, food, etc.

In presentations to healthcare providers it was important to highlight what Health Navigation was NOT:

- Emergency service
- Case management
- Health coach
- Discharge planner
- BUT it can assist all of these

The big picture of Health Navigation benefits to patients, providers and community was highlighted for healthcare providers, government, community partners and funders including:

- Access to payment source/meds
- Help address underlying social issues
- Can reduce ER visits, hospital admissions and readmissions
- Maximizes resources

Data Tracking and Reporting

Data tracking and reporting is critical to a successful program. Data measures can track quantity and quality; describe who is being served; and, measure the impact or difference the program is making in the community. The data also informs revisions or adjustments that may need to be made to improve the scope and quality of the program. As important as collecting the data is reporting the data. Reports allow staff, community partners and funders to view the data in a format that allows for description, trends and comparison.

Decisions

Prior to program implementation, there are a number of decisions that need to be made. The first decision is how will data be tracked:

- EMR
- Excel
- Other database

What will you track? Think about meaningful reports (process, descriptive and outcome); base the data tracked according to reports needed/wanted.

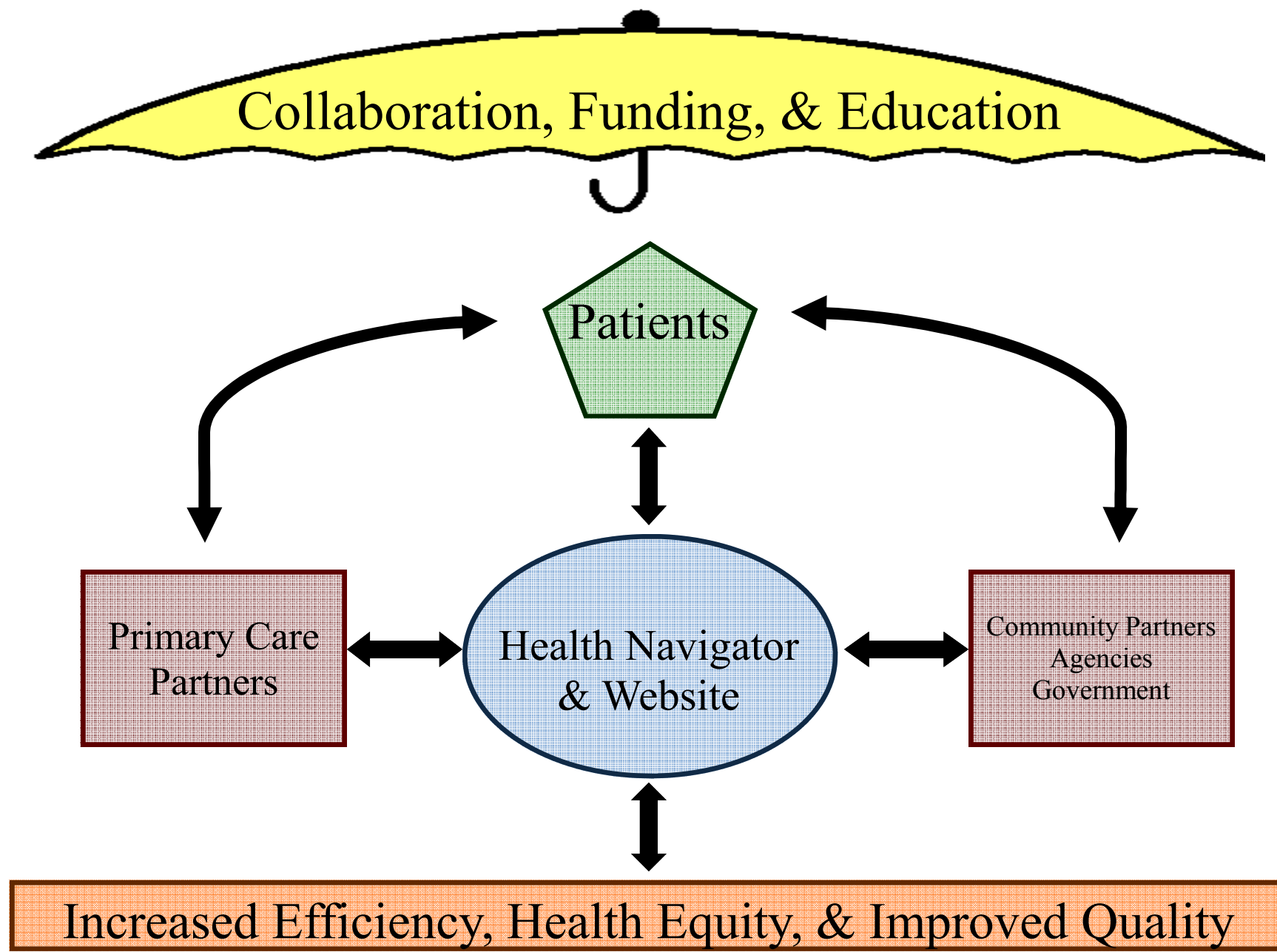
- Demographics
- Contacts
- Referrals
- Outcomes
- Barriers
- Follow-up dates
- Notes

Dallas County's Data Tracking & Reporting

Based on financial constraints, Health Navigation was initially done on an excel spreadsheet. As referrals increased and the program grew, the need for a more robust tracking system became apparent. A programmer was retained to help develop an access based Health Navigation tracking and reporting system. The ***Health Navigation Database User Manual (Appendix D)*** contains more detailed information.

Examples of reports created and utilized for Health Navigation include ***(Appendix G)***:

- Primary Presenting Issue by Type
- Referrals Provided for Access to Medical Care
- Other Program/Referrals Provided
- Barriers by Type
- Demographics (example – city of residence)
- Follow up dates (example - Tier 1)
- Referral Source by Client



Sample Health Navigation Clinic Referral Tool

Fax xxx.xxx.xxxx Phone xxx.xxx.xxxx

Clinic Name: _____ Date: _____

Name: _____ DOB: _____

Phone: _____

Release of Information authorizing exchange of information obtained? ☐ **Yes**

Areas of Need

- | | | | |
|--|--|---|----------------------------------|
| ☐ Help w/ Medical Insurance or Payment source | ☐ Medication Assistance | | |
| ☐ Parenting Skills | ☐ Counseling | ☐ Dentist | ☐ Food |
| ☐ Utilities Assistance | ☐ Child Care | ☐ Veterans | ☐ Tobacco |
| ☐ Substance Abuse | ☐ Domestic Abuse | ☐ Elderly Issues | ☐ Housing |
| ☐ Financial Assistance | ☐ Employment | ☐ Education Issues | ☐ Other |
| ☐ Maternal Child Health/ Child Development Issues | | | |

Reason For Referral

Appendix C **SAMPLE**
Health Navigation Screening Tool

Date of Referral: _____

Referral From: _____

Referral Reason: _____

Identifying Information

Date of screening _____

First Name _____ MI _____ Last Name _____

Address _____

Phone _____ Phone _____ Date of Birth: _____

Household Members

Name	Relationship	Birth Date

Medical Information

Medical Home ☐ Yes ☐ No Provider Name _____

Clinic Name _____

Health Insurance ☐ Private ☐ Hawk-I ☐ State Plan ☐ Medicaid
☐ Medicare ☐ Other ☐ None

Insurance Information & Number _____

Veteran Status ☐ Yes ☐ No

Meds for physical conditions _____

Pharmacy _____

If Medicare, Part D? ☐ Yes ☐ No

Dental Provider ☐ Yes ☐ No Date of Last Visit _____

Barriers to Medical Care

☐ No Insurance ☐ Unpaid Bill ☐ Transportation ☐ Hours
☐ Underinsured ☐ Fear ☐ SA/MH

Financial Information

Current/Last Employment _____

Hours _____ Wage _____ Kind of Work _____

Income

- | | | | |
|--|--|--|---|
| ☐ Employment | ☐ Self Employed | ☐ Unemployment | ☐ Spouse Salary |
| ☐ IPERS | ☐ Veterans/Military | ☐ Child Support | ☐ Interest |
| ☐ Social Security | ☐ Disability/SSDI | ☐ SSI | ☐ Retirement/Pension |
| ☐ FIP | ☐ Rent | ☐ Investment Income | ☐ Other |

Financial Resources

- ☐ Cash ☐ Checking ☐ Savings ☐ Stocks/Bonds/CDs
- ☐ Burial contract/Plot

Housing Information

- ☐ Own ☐ Rent ☐ Homeless ☐ Shelter ☐ Care Facility ☐ Transitional
- ☐ Family/Friends

Monthly Payment _____ Behind in Payment? _____

Other Expenses

Electric _____ Phone/Internet _____ Water _____ Loans _____

Gas _____ Garbage _____ Child Care _____

Child Support _____ Behind? _____

Support

- ☐ Section 8/Low Income/Sr & Dis ☐ LIHEAP ☐ SNAP ☐ Other

SA/MH

Utilize as appropriate

Current Mental Health Services ☐

Past Mental Health Services ☐

Provider(s) _____

Mental Health Diagnosis _____

Meds related to mental health _____

Developmental Disability ☐ Yes ☐ No

Diagnosis _____

Cognitive Impairment ☐ Yes ☐ No

Diagnosis _____

Substance Abuse ☐ Yes ☐ No

Drug(s) of Choice _____

Issues with Domestic Violence ☐ Yes ☐ No

Areas of Need

☐ Help w/ Medical Insurance or Payment source ☐ Medication Assistance

☐ Parenting Skills ☐ Counseling ☐ Dentist ☐ Food

☐ Utilities Assistance ☐ Child Care ☐ Veterans ☐ Tobacco

☐ Substance Abuse ☐ Domestic Abuse ☐ Elderly Issues ☐ Housing

☐ Financial Assistance ☐ Employment ☐ Education Issues ☐ Other

☐ Maternal Child Health/ Child Development Issues

Referrals Made Information

Organization/ Agency	Type of Service	Contact Name	Release Signed

Notes/Additional Information

Example Health Navigation Database User Manual

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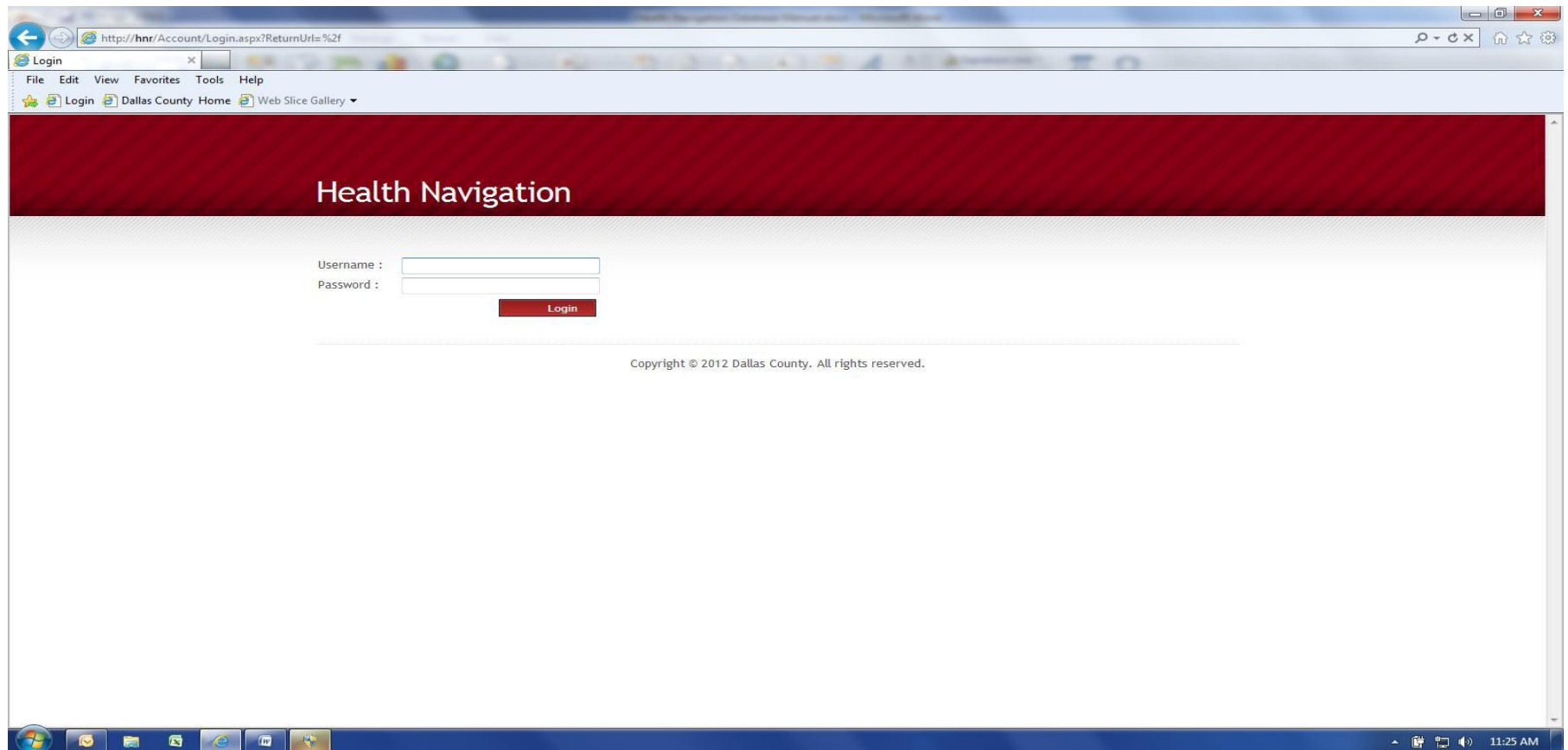
Sign On

Web address:

Username:

Password:

Click on “login”



The screenshot shows a web browser window with the address bar displaying `http://hnr/Account/Login.aspx?ReturnUrl=%2f`. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The address bar also shows a search icon, a refresh icon, and a home icon. The page title is "Login". The main content area has a red header with the text "Health Navigation". Below the header, there is a login form with two input fields: "Username :" and "Password :". A red "Login" button is positioned below the password field. At the bottom of the page, there is a copyright notice: "Copyright © 2012 Dallas County. All rights reserved." The Windows taskbar at the bottom shows the Start button, several application icons, and the system clock displaying "11:25 AM".

Health Navigation

Username :

Password :

Login

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Clients (List & Search)

Login will take you to the clients screen. The last 20 clients, that had a referral contact, will be displayed in most recent date order.

Clients

[Add Client](#) [Merge Clients](#)

Search:

	First Name	Last Name	Address	Phone	Email	Last Modified
View	Fka	Prince	, Waukee, IA			2/27/2012 10:34:58 AM
View	Pancho	Sanchez	, Perry, IA			2/27/2012 10:31:09 AM
View	Janis	Joplin	789 10th St., Bouton, IA	765-987-9999		2/27/2012 10:28:04 AM
View	jane	Anon	, Woodward,			2/27/2012 10:09:09 AM
View	Anon	2/13/12	, Adel, 50003			2/27/2012 10:04:52 AM
View	Suzanne	Tester	, Redfield,			2/27/2012 9:56:09 AM
View	Anon-1	1/31/12	, Waukee,			2/27/2012 9:54:34 AM
View	Steve	Tester	, Waukee,			2/27/2012 9:53:05 AM
View	Joe	Tester	, Waukee, 50001			2/27/2012 9:42:28 AM
View	Barney	Tester	, Dallas Center, 50001			2/27/2012 9:39:04 AM
View	Michael	Sample	6666, Adel, IA 50069			2/27/2012 9:31:03 AM
View	Anon-2	1/31/12	2222, birmingham, AL 50220	999-123-4444		2/27/2012 9:30:11 AM
View	Test	User	1123, Desoto, IA 11111	123-4444-5555		2/27/2012 9:27:12 AM
View	Jane	Doe	123 Willis , Perry, IA 50220	515-555-4444		2/27/2012 9:14:27 AM
View	Juan	Doe	456 Court St , Adel, IA 50003	515-993-7777		2/27/2012 9:12:19 AM
View	Juan	Doe	1781 Willis Perry, , 50220	515-465-5523		2/13/2012 11:01:15 AM
View	Fred	Tester	1234 5th St, adel, IA 50001	555-666-7777		2/10/2012 2:13:01 PM
View	Roberta	Sample	, Adel, 50003			1/31/2012 10:26:16 AM
View	David	Sample	, Perry, IA 50220	5154653223		1/31/2012 10:24:58 AM
View	Henry	Tester	, West Des Moines,			1/25/2012 10:40:07 AM

Showing 1 to 20 of 21 entries

[First](#) [Previous](#) [1](#) [2](#) [Next](#) [Last](#)

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Search – A search box is found on the upper right hand side of the screen. Search can be done utilizing first or last name and options that match become available as matching letters are being entered into the search box.

Navigating Through “Clients” Pages – Navigation keys to take you to additional “Clients” pages are located in the lower right hand corner of the page and include options of: first, previous, specific page numbers, next, and last.

View or Edit Client Information – Click directly on a client’s first or last name to view basic client demographic information.

View Client Referral Information – Click on the magnifying glass symbol next to a client’s name to view a list of referral(s) attached to that client.

Add Client – Click on “Add Client” at the top of the page to add a new client.

Merge Clients – ***THIS FUNCTION REQUIRES SPECIAL SECURITY***; therefore not all users will be able to perform this function. A merge will be performed when a client has been entered twice due to error, use of alias, hyphenated name, etc.

Add Client

If a client is not currently in the system, a new client will be added collecting contact and basic demographic information.

The screenshot shows a web browser window with the URL `http://hnr/Client.aspx`. The browser's address bar and menu bar are visible. The page has a red header with the text "Health Navigation" and a "Clients" button. The main content area is titled "Add Client" and contains a form with the following fields:

First Name :	Kermit
Last Name :	Frog
Address :	782 Greene St.
City :	Adel
State :	IA
Zip Code :	50003
Phone :	515-993-3333
Email :	Kermit@frogger.com
Gender :	☒ Male ☐ Female
Race :	Unknown
Ethnicity :	Non-Latino
Annual Income :	35000
Household Size :	3
Federal Poverty Level :	200%

Below the form are three buttons: "Add", "Cancel", and "Calculate". The "Calculate" button is only visible after the "Federal Poverty Level" field is filled. At the bottom of the page, there is a copyright notice: "Copyright © 2012 Dallas County. All rights reserved."

First Name – Enter first name. If client does not wish to provide first name enter “Anon”. If more than one client, not wishing to provide first **AND** last name, is received on the same day, the second client’s first name would be entered “Anon” with the number 2 following the name (ex. Anon-2).

Subsequent clients in this situation would be assigned the next chronological number. Refer to Appendix: “Naming Rules Cheat Sheet”

Last Name – Enter last name. If client provided first name but does not wish to provide last name enter “Anon” (ex. First Name = Maria; Last Name = Anon). If client does not wish to provide first **AND** last name, enter date (ex. First Name = Anon; Last Name = 1/31/12). Refer to Appendix: “Naming Rules Cheat Sheet”

Address – Two lines are allowed for street address. These fields are optional.

City – This field must be entered.

Zip code – Enter if known; this field is optional.

Phone – Enter if client wishes to provide. This field is optional.

Email – Enter if email is necessary to communicate with client. This field is optional.

Gender – This field must be selected (female/male). In the infrequent circumstance where gender is not apparent; or, someone does not wish to self identify, a gender must be assigned.

Race – This field is required and is a dropdown with choices (white, black, native American/native Alaskan, Hawaiian Islander/Pacific Islander, Asian, multi, unknown).

Ethnicity – This field is required and is a dropdown with choices (Latino, non-Latino)

Annual Income – This field is optional and should be entered **WITHOUT \$ sign, commas or cents** (ex. 30500).

Household Size – This field is optional.

Federal Poverty Level – If both annual income and household size are entered, click on “Calculate” and the system will automatically calculate percent of poverty level.

Add/Cancel – After all information has been entered, click on “Add” to add the record to the system. If for some reason the record should not be added, click on “Cancel”. Attempting to leave the screen without choosing “Add” or “Cancel” will result in a pop up message “If you leave this page any unsaved changes will be discarded. Please confirm that is desired.” Two options are then provided “Confirm” or “Cancel” and one must be chosen.

Please note that not all of the above information may be available in the first contact with client but may be collected during a later contact. For example, income and household size may be provided during a later contact when assisting with application for a benefit. As information becomes available, it is important that the information be updated via the “Edit” function.

Edit Client

Access this screen via the “Clients” page by clicking on the first or last name of the client you wish to edit.

The screenshot shows a web browser window with the URL <http://hnr/Client.aspx>. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The address bar shows the URL. The page has a red header with the text "Health Navigation" and a "Clients" button. The main content area is titled "Edit Client" and contains a form with the following fields:

- First Name : Pancho
- Last Name : Sanchez
- Address : (empty)
- City : Perry
- State : IA
- Zip Code : 50220
- Phone : (empty)
- Email : (empty)
- Gender : ☒ Male ☐ Female
- Race : White (dropdown menu)
- Ethnicity : Latino (dropdown menu)
- Annual Income : (empty)
- Household Size : 0 (spinner)
- Federal Poverty Level : (empty)

At the bottom of the form are three buttons: "Save", "Cancel", and "Calculate". Below the buttons, it says "Last Modified : 2/27/2012 10:28:51 AM". The footer of the page reads "Copyright © 2012 Dallas County. All rights reserved." The Windows taskbar at the bottom shows the time as 3:46 PM.

Edit necessary fields.

Save/Cancel – Select “Save” or “Cancel”. Attempting to leave the screen without choosing “Save” or “Cancel” will result in a pop up message “If you leave this page any unsaved changes will be discarded. Please confirm that is desired.” Two options are then provided “Confirm” or “Cancel” and one must be chosen.

Client Referrals

Review Summary – To view a list of current or previous health navigation referral(s) for a specific client, select the client from “Clients” screen and click on magnifying glass symbol next to the client’s name.

The screenshot shows a web browser window with the URL <http://hnr/ClientReferrals.aspx>. The page has a red header with the text "Health Navigation" and a "Clients" button. Below the header, the page title is "Client Referrals - Fka Prince". There is a link labeled "Add Referral". A table displays the referral data:

Primary Presenting Issue	Received	Referral Source	First Contact	Follow-Up Date 1	Follow-Up Date 2	Last Modified
Parenting/Childcare	2/1/2012	Tier 1 - Dallas Center Med Assoc.	2/1/2012	2/15/2012	2/29/2012	2/27/2012 4:20:44 PM

Below the table, it says "Showing 1 to 1 of 1 entries". There are navigation buttons: "First", "Previous", "1", "Next", and "Last". At the bottom of the page, there is a copyright notice: "Copyright © 2012 Dallas County. All rights reserved." The Windows taskbar at the bottom shows the time as 4:20 PM.

Add Referral – To add a referral click on “Add Referral”.

Edit Referral – To edit (revise or add information), regarding a specific referral, click on the primary presenting issue to be edited (ex. Parenting/Childcare).

View Referral Detail – To view referral detail, click on the primary presenting issue to be viewed (ex. Parenting/Childcare)..

Add Referral (Screen Section 1)

The screenshot shows a web browser window with the URL `http://hnr/Referral.aspx`. The browser's address bar and menu bar are visible. The page has a red header with the text "Health Navigation" and a "Clients" button. The main content area is titled "Add Referral - Lamb Chop".

The form contains the following fields and options:

- Date Received :
- Age Range :
- Date of First Contact :
- Referral Source :
- Follow-Up Date 1 :
- Follow-Up Date 2 :
- Primary Presenting Issue :

Below these fields are two sections of checkboxes for "Programs/Referrals" and "Other Programs/Referrals".

Programs/Referrals

☐ Hawk-I	☒ Venus
☐ Medicaid Program to include 3 day emerg, waivers, SLMB/QMB, etc	☐ Medication Assistance Voucher/Programs
☒ Iowa Care	☐ Clinic Assist
☐ Medicare/SHIP	☐ Hosp Assist
☒ Wauke Free Clinic	☐ PHC
☐ CFY	☐ Other

Other Programs/Referrals

☐ Medical General Info	☒ Dental	☒ Food
☐ Financial	☐ Parenting/Childcare	☐ Housing
☐ Elderly Issue	☐ Employment	☐ Substance Abuse/Mental Health
☐ Clothing	☐ Legal	☐ Domestic Violence

Add Referral (Screen Section 2)

http://hnr/Referral.aspx

Referrals

File Edit View Favorites Tools Help

Login Dallas County Home Web Slice Gallery

☒ Iowa Care ☐ Clinic Assist
☐ Medicare/SHIP ☐ Hosp Assist
☒ Wauke Free Clinic ☐ PHC
☐ CFY ☐ Other

Other Programs/Referrals

☐ Medical General ☒ Dental ☒ Food
☐ Financial ☐ Parenting/Childcare ☐ Housing
☐ Elderly Issue ☐ Employment ☐ Substance Abuse/Mental Health
☐ Clothing ☐ Legal ☐ Domestic Violence
☐ Transportation ☒ Utilities ☐ Other
☐ None

Barriers to Accessing Services

☐ Income ☐ Transportation ☐ Language ☐ Availability Location/Hours
☐ Childcare ☐ Cognitive ☐ None/Unknown

Succeeding Contacts

New	Contact Date	Note
No data to display		

Notes

Recently divorced & lost job. Doesn't know what to do for current medical/dental needs. Referred to free clinic and Vensus; Iowa Care if develop serious condition and PHC for dental needs. Also provided info on LIHEAP and food pantry.

Add Cancel

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4:52 PM

Date Received – Select the date that the referral was received from the calendar provided. This is the date the phone call, fax or email came into our office.

Age Range – Select the age range from the drop down selection.

Date of First Contact – Select the date that contact was first made with the client from the calendar provided. Please note that you may choose a past date; but, not a future date.

Referral Source – Select “Tier 1” or “Tier 2” from the drop down selection. Tier 1 referrals are those received from a medical provider and will require an additional drop down selection. If the referring provider is not a drop down choice, select “Other”. Tier 2 referrals are those received from a non-medical community partner or directly from the client or a family member; and, will require an additional drop down selection.

Follow-Up Date 1 – The date will automatically calculate and enter for two weeks from “Date of First Contact”. ***Checking in on client progress and follow up reporting to the Tier 1 referral source is required.*** A report can be run based on this date for the purpose of tracking and timely follow up. In the event of a Tier 2 referral source, the user may choose to delete this date or leave the date for follow-up if the client’s situation warrants (this will be at the discretion of the Health Navigator).

Follow-Up Date 2 – In the event of a Tier 1 referral source, the date will automatically calculate and enter for four weeks from “Date of First Contact”. ***Checking in on client progress and follow up reporting to the Tier 1 referral source is required.*** A report can be run based on this date for the purpose of tracking and timely follow up. In the event of a Tier 2 referral source, the user may choose to delete this date or leave the date for follow-up if the client’s situation warrants (this will be at the discretion of the Health Navigator).

Primary Presenting Issue – Select the client’s primary presenting issue from the drop down selection; **ONLY ONE** may be selected. Additional issues will be addressed under “Other Programs/Referrals”. However, if the client’s primary presenting issue is something other than “access to medical care”; but later in working with the client, “access to medical care” becomes an issue, an additional “Add Referral” page will need to be completed.

Program Referrals (Access to Medical Care) – If “Access to Medical Care” is selected as the primary presenting issue, the “Program Referrals” box will appear with a selection of programs/resources. Select **ALL** programs/resources to which the client is referred; multiple options may be selected. If the client is referred to a program/resource not specifically listed, select “Other”.

Other Programs/Referrals – Select **ALL** applicable programs/resources to which the client is referred; multiple options may be selected. If the client is referred to a program/resource not specifically listed, select “Other” and be sure to specify in “Notes” section.

Barriers to Accessing Services – Select **ALL** applicable barriers; multiple options may be selected. If no known barriers, select “None/Unknown”.

Notes – Use this space to briefly record the initial situation/contact with client. For example, “Recently divorced and lost job; and, has current medical and dental needs. Referred to free clinic and Venus for immediate needs; to Iowa Care if serious condition diagnosed and PHC for dental. Also provided LIHEAP and food pantry info.” For more information on notes/documentation refer to Appendix: “Health Navigation Notes/Documentation”.

Succeeding Contacts – This field will be used for future contacts with the client (see Edit Referral section of this manual). For more information on notes/documentation refer to Appendix: “Health Navigation Notes/Documentation”.

Add/Cancel – After all information has been entered, click on “Add” to add the referral record to the system. If for some reason the record should not be added, click on “Cancel”. Attempting to leave the screen without choosing “Add” or “Cancel” will result in a pop up message “If you leave this page any unsaved changes will be discarded. Please confirm that is desired.” Two options are then provided “Confirm” or “Cancel” and one must be chosen.

Edit Referral (Screen Section 1)

Referrals

File Edit View Favorites Tools Help

Login Dallas County Home Web Slice Gallery

Health Navigation

Clients

Edit Referral - Kermit Frog

Date Received : 02/24/2012

Age Range : 30 - 39

Date of First Contact : 02/27/2012

Referral Source : Tier 1 Mercy Adel

Follow-Up Date 1 : 03/12/2012

Follow-Up Date 2 : 03/26/2012

Primary Presenting Issue : Access to Medical Care

Programs/Referrals

☐ Hawk-I	☒ Venus
☒ Medicaid Program to include 3 day emerg, waivers, SLMB/QMB, etc	☐ Medication Assistance Voucher/Programs
☐ Iowa Care	☐ Clinic Assist
☐ Medicare/SHIP	☐ Hosp Assist
☐ Waukee Free Clinic	☐ PHC
☐ CFY	☐ Other

Other Programs/Referrals

☐ Medical General	☐ Dental	☒ Food
☐ Financial	☒ Parenting/Childcare	☐ Housing
☐ Elderly Issue	☐ Employment	☐ Substance Abuse/Mental Health
☐ Clothing	☐ Legal	☐ Domestic Violence

Edit Referral (Screen Section 2)

http://hnr/Referral.aspx

Referrals

[File](#)
[Edit](#)
[View](#)
[Favorites](#)
[Tools](#)
[Help](#)

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waivers, SLMB/QMB, etc

☐ Iowa Care
☐ Medicare/SHIP
☐ Wauke Free Clinic
☐ CFY

☐ Clinic Assist
☐ Hosp Assist
☐ PHC
☐ Other

voucher / Programs

☐ Medical General
☐ Financial
☐ Elderly Issue
☐ Clothing
☐ Transportation
☐ None

☐ Dental
☒ Parenting/Childcare
☐ Employment
☐ Legal
☐ Utilities

☒ Food
☐ Housing
☐ Substance Abuse/Mental Health
☐ Domestic Violence
☐ Other

Other Programs/Referrals

Barriers to Accessing Services

☒ Income
☐ Childcare
☐ Cognitive

☐ Transportation
☒ Language
☐ None/Unknown

☐ Availability Location/Hours

Succeeding Contacts

	Contact Date	Note
New	2/28/2012	Client called re concern of interpreter for Piggy as she speaks Portugese. Advised client to let all agencies know prior to appts and agencies would find interpreters.

Notes

Calling in regard to uninsured pregnant girlfriend (Ms Piggy). Referred Piggy to Medicaid for ins. covg. Also referred to WIC and DCPHN MCH program. Client states pregnancy was unintended from his side; referred to VENUS family planning.

Save

Cancel

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Edit Referral/Succeeding Contacts (Screen Section 3)

http://hnr/Referral.aspx

Referrals

File Edit View Favorites Tools Help

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☒ Medicaid Program to include 3 day emerg, waivers, SLMB/QMB, etc
 ☐ Medication Assistance Voucher/Programs

☐ Iowa Care
 ☐ Clinic Assist

☐ Medicare/SHIP
 ☐ Hosp Assist

☐ Wauke Free Clinic
 ☐ PHC

☐ CFY
 ☐ Other

Other Programs/Referrals

☐ Medical General
 ☐ Dental
 ☒ Food

☐ Financial
 ☒ Parenting/Childcare
 ☐ Housing

☐ Elderly Issue
 ☐

☐ Clothing
 ☐

☐ Transportation
 ☐

☐ None

Barriers to Accessing Service

☒ Income
 ☐ Transportation

☐ Childcare
 ☐ Cognitive

Succeeding Contacts

New

Contact Date	Note
	Calling in regard to uninsured pregnant girlfriend (Ms Piggy). Referred Piggy to Medicaid for ins. covg. Also referred to WIC and DCPHN MCH program. Client states pregnancy was unintended from his side; referred to VENSU family planning.

Save Cancel

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11:05 AM

When to Utilize the Edit Function

Correction or Addition of Information (Screen Sections 1 & 2)

Referrals should only be edited for correction of information or addition of information (ex. additional referrals provided, additional barriers to access, addition or correction/clarification in notes, etc.). **The editing function should not be used to delete information.** Edit necessary fields.

Save/Cancel – After necessary fields have been edited, click on “Save” or “Cancel”. Attempting to leave the screen without choosing “Save” or “Cancel” will result in a pop up message “If you leave this page any unsaved changes will be discarded. Please confirm that is desired.” Two options are then provided “Confirm” or “Cancel” and one must be chosen.

Succeeding Contact(s) (Screen Section 3)

After the initial contact, all succeeding contact will be entered in this section. **Do not add succeeding contact(s) in the general “Notes” section.**

Add a Contact

Scroll to the “Succeeding Contacts” area of the screen. Click on “New” and an “Edit Form” box will pop up.

Date of Contact - Select the date that contact was made with the client from the calendar provided. Please note that you may choose a past date; but, not a future date.

Succeeding Contact(s) Note - Enter brief information in this area. Should the original user be out of the office, this information should be enough to guide someone else in the event of a future client contact. For more information on notes/documentation refer to Appendix: “Health Navigation Notes/Documentation”.

Update/Cancel – After all information has been entered, click on “Update” to add the contact to the system. If for some reason the contact should not be added, click on “Cancel”. Once “Update” is selected, you will be taken back to the “Update Referral” screen.

Save/Cancel – Before leaving the “Update Referral” screen, “Save” or “Cancel” must be selected. Attempting to leave the screen without choosing “Save” or “Cancel” will result in a pop up message “If you leave this page any unsaved changes will be discarded. Please confirm that is desired.” Two options are then provided “Confirm” or “Cancel” and one must be chosen.

Edit a Contact

Scroll to the “Succeeding Contacts” area of the screen. Click on “Edit” next to the contact to be revised and an “Edit Form” box will pop up. **The editing function should not be used to delete information.** Edit the date and/or note. For more information on notes/documentation refer to Appendix: “Health Navigation Notes/Documentation”.

Update/Cancel - After all information has been revised, click on “Update” to add the contact to the system. If for some reason the contact should not be added, click on “Cancel”. Once “Update” is selected, you will be taken back to the “Update Referral” screen.

Save/Cancel – Before leaving the “Update Referral” screen, “Save” or “Cancel” must be selected. Attempting to leave the screen without choosing “Save” or “Cancel” will result in a pop up message “If you leave this page any unsaved changes will be discarded. Please confirm that is desired.” Two options are then provided “Confirm” or “Cancel” and one must be chosen.

Please note - after the client’s referral has been entered in the system, all succeeding contact for that specific referral should be entered utilizing the edit function. Please note - if 60 days has passed since the referral’s date of first contact, a new referral record will be required.

Appendix

Health Navigation Database Naming Rules Cheat Sheet

Info Provided	<i>First Name</i>	<i>Last Name</i>
First & Last Name	<i>First Name</i> as provided	<i>Last Name</i> as provided
<i>First Name</i> Only	<i>First Name</i> as provided	Anon
<i>Last Name</i> Only	Anon	<i>Last Name</i> as provided
No name provided	Anon	Today's Date
2nd No name provided today	Anon-2	Today's Date

Examples:

John Smith calls – Enter **John** in *First Name* and **Smith** in *Last Name*

Esther calls – Enter **Esther** in *First Name* and **Anon** in *Last Name*

Mrs. Howard calls – Enter **Anon** in *First Name* and **Howard** in *Last Name*

A man calls on 3/19/2012 and does not give his name – Enter **Anon** in *First Name* and **3/19/2012** in *Last Name*

A different man calls on 3/19/2012 and does not give his name – Enter **Anon-2** in *First Name* and **3/19/2012** in *Last Name*

Health Navigation Notes/Documentation

Health Navigation notes are critical for documentation of the services provided to each client. Health Navigation notes should be clear, concise, brief, accurate, timely and factual. Health Navigation notes should describe the situation/need and services provided by Health Navigator; and, document referrals made and client's progress.

- Utilize the “Notes” section of the referral page in the Health Navigation database to record the initial situation/contact with the client. Each additional contact with, or on behalf, of the client must be documented in the “Succeeding Contacts” section.
- Make every attempt to enter Health Navigation notes during the interaction or immediately following the interaction; make sure it is recorded on the system under the date it actually occurred. Health Navigation notes must be entered within one business day of the contact.
- At the beginning of the Health Navigation note, state the mode of contact first: telephone (TC), office visit (OV), home visit (HV), collateral contact (CC). At the end of the note, conclude with your initials.
- When writing a Health Navigation note, don't write a volume; but, give enough detail that if you are out of the office tomorrow, another staff can assist the client with minimal duplication of effort (include contact names and telephone numbers of those you are working with)
- Do not record client statements as facts. Utilize “client states” or “client reports”
- Do not assign psychological terms to a client such as “bipolar” “post-traumatic stress disorder”, etc unless it is part of the medical record. Avoid diagnoses, clichés, street jargon, stereotypes and prejudices.
- Utilize the word “client” and any other related persons by their relationship to the client followed by their name the first time used (ex. Client states he is living with his brother, Todd. Brother is paying housing expenses.)
- Utilize the abbreviation HN for yourself
- If the contact is with someone other than the client and there is no release in the file, note there was no release and you did not provide the caller with info
- If the Health Navigation note documents a potentially serious problem such as extreme depression or client making statements regarding suicide or threats to others, make sure you follow it up with the action you took and immediately consult with your supervisor

Reports Available

Creating reports requires special security; therefore, not all users will be able to perform this function.

Referral Source by Client – Timeframe must be selected and will be based on “Date Received” from Referral Screen. The report will show individual Tier 1 and Tier 2 clients broken down by referral source. Please note, there could be duplicate clients from various referral sources if the timeframe selected is more than a 60 day period.

Unique Clients Served – Timeframe must be selected and will be based on “Date of First Contact” and/or “Succeeding Contacts Contact Date” from Referral Screen. This will provide a list of unduplicated clients.

Tier 1 Follow-up Dates – Timeframe must be selected and will be based on “Follow-up Date 1” or “Follow-up Date 2” falling within the range.

Tier 2 Optional Follow-up Dates - Timeframe must be selected and will be based on “Follow-up Date 1” or “Follow-up Date 2” falling within the range.

All Client Contacts/First Contact – Timeframe must be selected and will be based on “Date of First Contact” from Referral Screen. This can be added with All Client Contacts/Succeeding Contacts report to find the total number of client contacts during a specific period. In addition, the total number of contacts can be divided by Unique Clients Served report for the same timeframe to find the average number of contacts per client.

All Client Contacts/Succeeding Contacts – Timeframe must be selected and will be based on “Succeeding Contacts Contact Date” from Referral Screen. This can be added with All Client Contacts/First Contact report to find the total number of client contacts during a specific period. In addition, the total number of contacts can be divided by Unique Clients Served report for the same timeframe to find the average number of contacts per client.

Referral by Type/Access to Care – Timeframe must be selected and will be based on “Date of First Contact” and/or “Succeeding Contacts Contact Date” from Referral Screen. This can be added with Referrals by Type/Other report to find the total number of client referrals during a specific period. In addition, the total number of referrals can be divided by Unique Clients Served report for the same timeframe to find the average number of referrals per client.

Referral by Type/Other – Timeframe must be selected and will be based on “Date of First Contact” and/or “Succeeding Contacts Contact Date” from Referral Screen. This can be added with Referrals by Type/Access to Care report to find the total number of client referrals during a specific period. In addition, the total number of referrals can be divided by Unique Clients Served report for the same timeframe to find the average number of referrals per client.

Demographics - Timeframe must be selected and will be based on “Date of First Contact” and/or “Succeeding Contacts Contact Date” from Referral Screen. This will provide an unduplicated count. Each demographic listed below must be run separately.

- Gender
- Age
- Race
- Ethnicity
- City
- FPL (Because income is an optional field, information will only be provided on clients who have income and family size entered.)

Primary Presenting Issue by Type – Timeframe must be selected and will be based on “Date of First Contact”. This report will provide a total for each type of issue.

Barriers by Type – Timeframe must be selected and will be based on “Date of First Contact” and/or “Succeeding Contacts Contact Date” from Referral Screen. This report will provide a total for each type of barrier.

Contacts with Notes – This report prints all notes (both initial and succeeding) on a specific client. This is utilized for reporting back to Tier 1 medical providers.

Appendix E

Sample Health Navigation Policy

Status: Approved

Issue Date: xx.xx.xx

The goal of Health Navigation Coordination is to improve comprehensive, coordination and continuity of care for Dallas County residents. The program supports medical providers and agencies in Dallas County through facilitation and follow-up of patient/client referrals to community resources. The program is available to any Dallas County resident with priority given to patients who are referred by a medical provider.

References

The references listed below are resources that may help you understand and complete this procedure. If you need help locating the noted references, see your supervisor or manager.

NUMBER	DESCRIPTION
1	Iowa Public Health Standards

Exhibits

The exhibits listed below are a compilation of sample forms, screen printouts, etc. that provide a useful visual guide when performing a task in a specific program.

NUMBER	DESCRIPTION
1	Health Navigation Clinic Referral Tool
2	Health Navigation Screening Tool
3	Health Navigation Database User Manual
4	Health Navigation Postcard
5	Health Navigation Call Record

Procedure:

STEP	ACTION
1	The Health Navigator will promote the program to community agencies; and, the Public Health Nurse Clinician will promote the program to medical providers via face to face contact and distribution of written materials. Medical providers will be considered Tier 1 referrals (patients) and all others will be Tier 2 referrals (clients).
2	Tier 1 providers will obtain a release of information from the patient authorizing exchange of information between the provider and the Health Navigator. For Tier 1 and 2 referrals, the Health Navigator will obtain appropriate releases as necessary.
3	Tier 1 providers will complete a brief "Clinic Referral" including: clinic name, referral date, patient name, date of birth, and reason for referral. The referral will be faxed to the Public Health Nurse Clinician for review and tracking

	purposes. The Public Health Nurse Clinician will provide the referral to the Health Navigator along with additional medical information if necessary.
4	The Health Navigator will contact the patient/client being referred within three business days.
5	The Health Navigator will meet with the patient/client face to face or via phone and complete a "Health Navigation Screening" to obtain pertinent information and determine potential needs and resources available. The Health Navigator along with the patient/client will determine the amount of information collected.
6	The Health Navigator will document all referrals made and/or follow-up action in the Health Navigation database. The Public Health Nurse Clinician will review the database information, make any revisions necessary, and provide the information to the Tier 1 provider.
7	The Health Navigator will contact Tier 1 patients at a minimum two weeks and four weeks from the original date of screening to check on progress/need for further assistance. Additional contact may be made as deemed necessary in accordance with specific circumstances. Tier 2 patients will be contacted as needed.
8	The Public Health Nurse Clinician will report each patient contact/progress to Tier 1 providers by either fax or mail.
9	If after 4 weeks the Health Navigator has been unable to reach the patient/client, the patient/client has declined assistance, or it appears the patient/client is unwilling to take the steps recommended, the Health Navigator will consider the patient/client's file closed and report this action to the Public Health Nurse Clinician who will notify the Tier 1 provider via fax or mail.
10	For tracking and reporting purposes, the Health Navigator will enter each patient/client into the Health Navigation Database at referral and continually update as actions/contacts/referrals are made.
11	After the end of each month, the Community Health Coordinator and Office Manager will run Health Navigation Database reports to monitor and report Health Navigation activity.
12	All Tier 1 referrals will be monitored by the Public Health Nurse Clinician, in addition to the Health Navigator, on an ongoing basis. In the event of unresolved Tier 1 issues/cases, the Public Health Nurse Clinician will work with the Health Navigator and medical provider to assist with progress or conclusion of the file.



Health Navigation



Locating and accessing needed services can sometimes be difficult, confusing or even overwhelming.

The Health Navigator can help Dallas County residents locate and access resources, explore options, and navigate systems.

Please contact:

Vivian De Gonzalez
515.993.3750 or
515.465.2483
800.811.7565

Supported by:



United Way of Central Iowa

Text Box

Health Navigation can assist in health-related areas including:

- Access to and payment for medical care including medications
- Mental health/substance abuse
- Basic needs such as food and safe, affordable housing
- Parenting/Childcare
- Aging Issues

Appendix G
Report Examples

Primary Presenting Issue by Type		
3/1/13 - 3/31/13		
Primary Issue Type	Number	Percent
Access to Medical Care	38	73%
Financial	4	8%
Food	2	4%
Housing	1	2%
Legal	2	4%
Parenting/Childcare	1	2%
Sub Abuse/Mental Health	2	4%
Transportation	2	4%
Total	52	

Referrals Provided for Access to Care		
3/1/13 - 3/31/13		
Program/Referral for Access to Medical Care	Number	Percent
Care for Yourself	19	24%
Clinic Assistance	7	9%
hawk-i	1	1%
Hospital Assistance	6	8%
Iowa Care	11	14%
Medicaid Programs (all incl waivers)	4	5%
Medication Assistance Voucher/Programs	6	8%
Free Clinic	15	19%
Other	11	14%
Total	80	

Other Program/Referrals Provided		
3/1/13 - 3/31/13		
Program Referral	Number	Percent
Elderly Issue	1	2%
Employment	2	4%
Financial	14	25%
Food	6	11%
Housing	3	5%
Legal	3	5%
Medical General Info	1	2%
Parenting/Childcare	5	9%
Sub Abuse/Mental Health	7	12%
Utilities	7	12%
Other	8	14%
Total	57	

Barriers by Type		
3/1/13 - 3/31/13		
Service Barrier	Number	Percent
Availability Location/Hours	4	5%
Childcare	2	2%
Cognitive	1	1%
Income	34	42%
Language	23	28%
None/Unknown	9	11%
Transportation	8	10%
Total		

City of Residence		
3/1/13 - 3/31/13		
City	Number	Percent
Adel	10	19%
DeSoto	1	2%
Minburn	2	4%
Perry	25	48%
Redfield	3	6%
Van Meter	1	2%
Waukee	8	15%
Woodward	2	4%
Total	52	

Tier 1 Follow up Dates		
Run Date 8/26/13		
Client Name	F/U 1	F/U 2
XXXXXXXXXX		8/28/2013
XXXXXXXXXX	9/2/2013	9/16/2013
XXXXXXXXXX	9/5/2013	9/19/2013
XXXXXXXXXX	9/9/2013	9/23/2013
XXXXXXXXXX	9/9/2013	9/23/2013

Referral Source by Client	
3/1/13 - 3/15/13	
Tier 1	
Source:	Mercy Perry
Client Name	Number Referrals
XXXXXXX	1
XXXXXXX	1
Subtotal	2
Source:	Unity Point Waukee
Client Name	Number Referrals
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
Subtotal	3
Source:	Free Clinic Waukee
Client Name	Number Referrals
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
Subtotal	5
Total Tier 1	10
Tier 2	
Source:	Community Partner
Client Name	Number Referrals
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
Subtotal	4
Source:	Self/Family
Client Name	Number Referrals
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
XXXXXXX	1
Subtotal	5
Total Tier 2	9
Total Tier 1 & 2	19